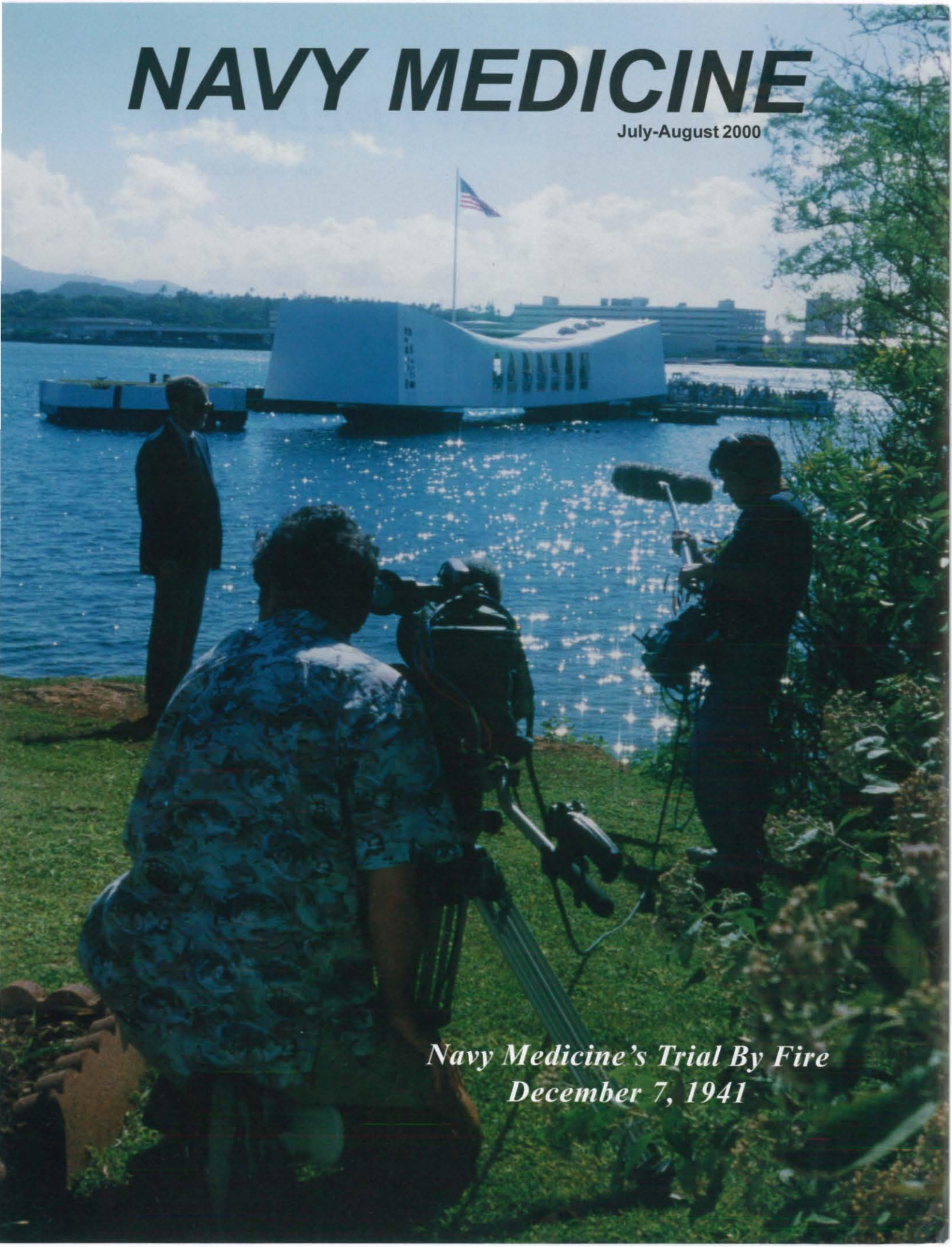
NAVY MEDICINE

July-August 2000



Navy Medicine's Trial By Fire
December 7, 1941

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COVER: The Bureau of Medicine and Surgery has just released Part 1 of its new video series on Navy medicine in World War II. With the USS Arizona Memorial as a backdrop, Medical Department Historian Jan K. Herman and camera crew shoot the closing scene of "Navy Medicine's Trial By Fire: December 7, 1941." Story on page 4. Photo by John Lewin.

Photo by LCDR W. Haissig

The author collects source water samples upstream of site 2 in Caraballeda.

Quenching Venezuela's Thirst: A Dispatch From Joint Task Force Fundamental Response

LTJG Ardath A. White, MSC, USNR

The small windows on our C-130 obscured the damage to the northern coastline of Venezuela but, on landing, the destruction was painfully obvious. During December 1999, La Niña dropped more than 65 inches of rain on the country with greater than half of it falling in just 2 days, 15 and 16 December. The torrential rainfall triggered mudslides and floods that ultimately killed 40,000 people and left close to 500,000 homeless. Navy Environmental and Preventive Medicine Unit No. 2 (NEPMU-2) was asked to send an environmental health officer and a preventive medicine technician to support initial forces deployed to the devastated area.

On New Year's Eve, HM2 Adelina Luna-Simpson and I were standing in the midday summer heat in front of our new home, the Aeropostal hangar at Simon Bolivar International Airport in Maiquetia, Venezuela.

When the joint task force was established, the mission was focused on search and rescue operations. This quickly changed to humanitarian assistance that included delivering food and supplies, creating potable water, and rebuilding the coastal road that was destroyed by mudslides in order to reconnect several isolated cities. HM2 Luna-Simpson and I were sent to Venezuela to conduct water sampling. But, like the mission of the task force, our mission also changed and expanded to include other aspects of force health protection such as medical surveillance and sickcall.

Our first tasking was to survey our new home. The Aeropostal airplane hangar that housed the task force was not exactly ideal, but was dry and undamaged, unlike the surrounding areas. Initially the airport was closed to commercial traffic, but by the second week of January, services had been restored. Our living area was only about 200 meters away from where commercial aircraft took off and landed about 20 hours a day, and worse only 50 meters from the Chinook helicopters that were home to the aircrews. Sound level dosimetry readings routinely hit peaks of 134

decibels at individual racks in the hangar with peaks to 140 decibels from the Chinooks. Although the overall average level was not damaging, personnel were concerned about their exposure to the brief bursts of loud, frequently painful noise.

The hangar also lacked basic sanitation services. Feral dogs and cats, pigeons, bats, insects, and even a boa constrictor were houseguests. No eating area had been designated until our arrival at which time a café-like area was established and eating in the area of cots was discontinued. Airport personnel initially supplied portable toilets but they were only cleaned once weekly, with the fecal waste being dumped into the open rain gutters that ran next to the hangar. This unacceptable practice was halted immediately and a new contractor was found. However, cleaning continued to be infrequent and personnel were confused by the "flushing handles" that were designed to move chemical cleaning and deodorizing agents through the collection area. The flushing handles operated just like a gearshift lever, which inspired us to write creative instructions for the personnel with visual aids including a paper clutch pedal taped to the door.

Now happy with our home, we focused attention elsewhere. The abrupt cancellation of the massive engineering effort that was to rebuild the coastal road using Navy and Marine assets switched the focus of the task force to the manufacturing of potable water. Four reverse osmosis water purification unit (ROWPU) sites were established and Army National Guardsmen from Puerto Rico, the Virgin Islands, Florida, and North Dakota operated 10 ROWPUs.

Because of the magnitude of destruction, the sites were located in two states and the landscape and conditions varied at each site. Site 1 was at a yacht club in Catia la Mar.

Two 3,000-gallon-per-hour (gph) ROWPUs set up by the Puerto Rican quartermasters were the first to operate in the region. Site 2, which turned out to be a continual challenge to ROWPU crews, was in Caraballeda, a once beautiful resort area that suffered the most damage.

Rocks and mud buried the first story of all the buildings and a 35-foot wave of muddy water saturated what was left. In addition, the residents lost everything they had at the hands of looters who carted off all of their personal belongings, even major appliances. Working in that environment was not only depressing, but posed unknown dangers to U.S. personnel from further flooding, mudslides, and armed vandals.

Photos by author

Damaged water and sewer pipes, destroyed bridges, washed out roads, and widened streams were all evident in Catia La Mar, after the December 1999 rains.

The initial location for the two 600-gph ROWPUs was next to a muddy river that flooded with even the slightest amount of rain. It was quickly discovered that the river's course had been reengineered in the 1960s to run a different route in order to allow the creation of more resort communities. After the December rains, the river had gone back to its original course and was running exactly where the ROWPU was now located. With the original river banks filled in, the area was now a flood plain.

After 2 difficult weeks in that location, Venezuelan engineers again rediverted the river. The ROWPU was relocated onto a bridge away from the muddy waters. In addition to the difficulties involved with making water, personnel at the site lived in the remains of an unfinished building that had no water or electricity. And to make matters worse, during daytime they worked without any shade in full sun and at night time were ruthlessly bitten by mosquitoes, despite heavy layers of DEET, permethrin treated clothing, and biweekly aerosol spraying by the Venezuelan government.

Sites 3 and 4 were located in the state of Miranda. There the damage was a result of flooding and not mudslides. The dam that supplied water to 90 percent of the state had burst and ROWPUs were the only immediate source of potable water for the residents. The lack of a distribution network was the problem that most plagued the ROWPUS at those sites. Site 4, the location for two 3,000-gph ROWPUs, was only being served by four small water tanker trucks which were filled with water that took only 30 minutes to manufacture. At site 3, distribution was not only impaired, but was suspected to be un-

Two 600 gph ROWPUs operated by the Puerto Rican National Guard supplied water to the destroyed town of Caraballeda.

fair too. This cost the driver of a government water truck one of his ears when crowds mobbed the truck to get the water. While U.S. personnel were very careful not to get involved with these problems, the frustration surrounding distribution certainly placed them at risk.

As difficult as water production was, so too was the water testing. Initially the only way to get to three of the sites was by helicopter. While this was certainly an exciting way to travel, it was time-consuming and logistically difficult. Even when roads finally reopened, the route to one site, site 2, took about 2 hours to drive, despite being only a few miles away.

Water samples were collected for both biological and chemical analysis. For biological testing, we relied on the qualitative Colilert test. If samples were positive, regardless of the actual amount of coliforms, the water would not be distributed. This initially caused confusion with Hidrocapital, the government-operated water utility, as they relied on plate counts when testing water quality. Fortunately HM2 Luna-Simpson, who was fluent in Spanish, was able to work with the staff and explain our methods of testing. This in turn improved their testing procedures so that results from both organizations correlated.

Chemical testing of potable water was identified as a priority only after we arrived. Turbidity, total dissolved solids (TDS), free-available chlorine (FAC), and pH could be measured using the ROWPU's test kits, but because of the nature of the destruction, concerns were raised about potentially high amounts of heavy metals and other chemical contaminants. A Hach Corporation Direct Reading Environmental Laboratory (DREL) was forwarded to us from NEPMU-2 so that chemical analysis could be performed. Although highly portable, the DREL unfortunately has a fairly limited capability. Therefore, it was only able to give us a vague hint of possible pollutants but not an in-depth analysis. Even so, it did provide valuable feedback to the ROWPU staff who were then able to change out filter cartridges or adjust their procedures based on our results. The DREL also verified that the product water we supplied to the Venezuelans was well within U.S. Environmental Protection Agency standards for drinking water.

By the end of January, the state of Vargas began to reestablish a level of normalcy. Venezuelan engineers worked long hours to restore the municipal water system and clear the destroyed roads and towns. Residents were slowly being allowed back into the areas that had restricted access due to the destruction from mudslides.

Routine settled in for us too, and it was quite clear that the task force role would not expand. My services were no longer needed so HM2 Luna-Simpson capably assumed all the preventive medicine duties. As I left Maiquetia Airport, this time on a commercial airplane, clouds of dust from the clean-up effort loomed along the northern coast of Venezuela, very different from the ominous December storm clouds that rained down death and destruction. It was evident that the Venezuelans were striving hard to overcome the tragedy and I was happy that NEPMU-2 was there to help provide safe water through their rough times. ❑

LTJG White is an environmental health officer at the Navy Environmental and Preventive Medicine Unit No.2, Norfolk, VA.

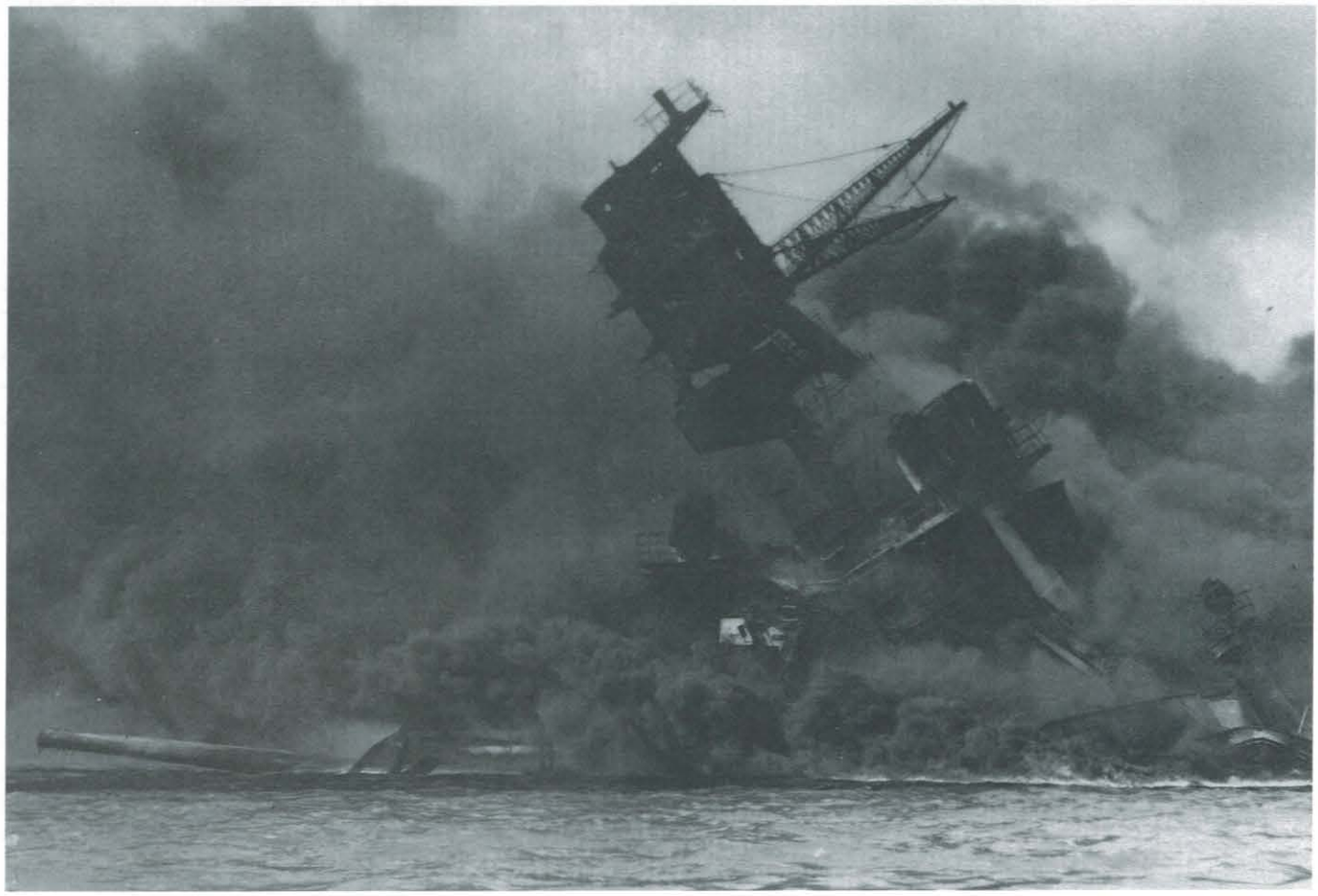
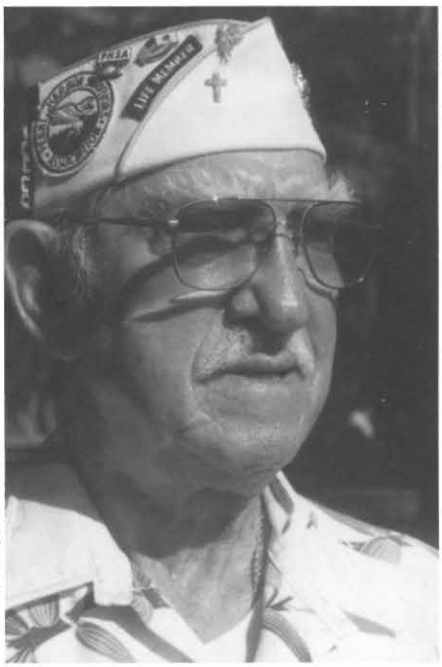


Photo from BUMED Archives

USS *Arizona* - 7 December 1941

World War II Video Series Underway



Photos by John Lewin

MSGT Richard Fiske, USAF (Ret.) blows taps for his fallen shipmates. MSGT Fiske was a Marine Corps bugler aboard USS *West Virginia* (BB-48) on 7 December 1941 when Japanese torpedoes sent her to the bottom of Pearl Harbor.

The Bureau of Medicine and Surgery has just released the first installment in its new seven-part video series *Navy Medicine at War*. The series is based on oral interviews with Medical Department veterans of World War II—physicians, dentists, nurses, and hospital corpsmen who saw the war from their own unique perspectives. It is the story of those tested on the most famous battlefields of World War II—Pearl Harbor, Guadalcanal, Peleliu, Normandy, Iwo Jima, and Okinawa. But it is also the account of medical personnel practicing Navy medicine in submarines operating deep in enemy waters, aboard vessels under kamikaze attack, aboard hospital ships, and in POW camps scattered throughout Japan and the Philippines.

World War II ended on the deck of USS *Missouri* (BB-63). Now a museum ship at Pearl Harbor, the great battleship is an appropriate backdrop as Jack Lewin directs one of the opening scenes.

The series, produced by the Naval School of Health Sciences in cooperation with the Bureau of Medicine and Surgery, will cover the war from Pearl Harbor to the final surrender of Japan. Each 25-minute show combines on-screen veteran interviews with combat footage gathered from the National Archives, Library of Congress, and other repositories. The goal of the series is to inform and educate a new generation about an era, now over a half-century ago, when men and women of Navy medicine helped decide the contest between fascism and freedom. ❑

Medical Department Historian Jan Herman (left) and Director Jack Lewin from the Naval School of Health Sciences, Bethesda, MD, discuss the script of "Navy Medicine's Trial By Fire."

You may order Part 1, "Navy Medicine's Trial by Fire: December 7, 1941," by contacting Mr. Lewin at email: jmlewin@nsh10.med.navy.mil. Use Trial by Fire in the subject line.

Feature

Navy Medicine in the Forgotten War

Korea 1950-1953

Part II

CAPT Eugene H. Ginchereau, MC, USNR

The Inchon Landing

While UN forces were fighting delaying tactics and struggling desperately to preserve the defensive perimeter around Pusan, GEN Douglas MacArthur, now Commander-in-Chief, UN Command, was formulating a bold plan for an amphibious landing at Inchon on the west coast of Korea. He believed that the NKPA (North Korean People's Army) had overextended its supply lines and that it was weaker numerically and logistically than supposed. If these lines of supply and communication to the north were interdicted, he reasoned, the NKPA would be forced to retreat from the Pusan area or face certain defeat.

Many military planners including the Joint Chiefs of Staff considered the plan too risky. Failure, they opined, would lead to a military disaster, hastening the UN withdrawal from the peninsula. But, through force of argument and character, MacArthur prevailed.

On 15 September 1950, without training or dress rehearsals, the First Marine Division, consisting mostly of newly recruited reservists, assaulted Inchon Harbor. Within 12 days the Division, acting with supporting units of UN X Corps, occupied Seoul.

The First Medical Battalion provided the medical support for the Division. The Division Surgeon was CAPT Eugene Hering, MC, USN and the Battalion commanding officer was CDR Howard A. Johnson, MC, USN. The Battalion, except for C Company, which served with the First Provisional Marine Brigade, was undertrained and inexperienced. Only 50 percent of the men in the Battalion received any field training, and it had barely 2 weeks to organize to war strength prior to embarkation. The officers received only one lecture on the general planning and preparation for combat.(*1*)

The Battalion was composed of one hospital and service company (H&S), two hospital companies (A and B), and three collecting and clearing companies (C,D, and E). Clearing platoons of C,D, and E Companies operated clearing hospitals; collecting platoons operated with infantry battalions.

In the planned forward positioning of medical units, "Inchon had the dis-

tinction of being the first amphibious assault in which carefully planned medical techniques were integrated with military operations."(*2*) These units were the three surgical teams temporarily assigned to the Battalion and three casualty teams from A and B companies.

The surgical team was an innovation necessitated by the shortage of medical officers. It was designed to be a highly mobile, rapid response group capable of operating independently. Each surgical team included three physicians, a Medical Service Corps officer, and 10 hospital corpsmen. The team had its own equipment and was capable of independently providing definitive surgery anywhere in a battle area. At any one time there were 25 teams in service during the war.(*3*)

There was one medical officer and 6 hospital corpsmen in the casualty teams. Like the surgical teams these were to be assigned to LSTs which were to be beached during the initial assault. Thereafter, they would provide front line care to the assault forces.

As planned, the surgical teams, casualty teams, and collecting platoons from C and D companies were in the initial assault on D-day and provided immediate battle line care. LST(H)-898 became a beach hospital and was performing surgery on the critically injured almost immediately. Personnel from this vessel responded to numerous requests of Marines to retrieve wounded on the beach that might not have been saved otherwise.(*4*)

By D-day + 2, the Division Hospital was established in a school house east of Inchon. At 1500 it was ready to receive casualties, and 47 patients were admitted.(*5*)

As the Marines quickly moved inland, components of the Medical Battalion moved with them. On D-day + 4, a clearing hospital was established at Kimpo Air Field, northeast of Seoul. When the 121st Army Evacuation Hospital was set up at Yongdongpo, just outside Seoul, on D-day + 15, casualty receiving was discontinued at the Division Hospital. Fifteen days later—30 September—the mission of the Medical Battalion ended.

The accomplishments of this unit were truly impressive. It not only supported the Division but also gave initial support to units of X Corps, including one ROK (Republic of Korea) Regiment, and the U.S. Seventh Division. In doing so, the Battalion treated 5,516 patients. There were 2,484 surgical cases and 6 post-operative deaths. Only nine died after admission to a first aid station; 99.43 percent of all patients survived after evacuation, meaning that a wounded Marine had a 199 to 1 chance of surviving a wound.(*6*)

Mention should also be made of the contributions of the three hospital ships supporting the Inchon Landing—the USS *Consolation* (AH-15), USS *Haven* (AH-12), and USS *Repose* (AH-16). These ships provided vital definitive surgical and medical care throughout the operation.

The Chosin Reservoir Campaign

After the successful landings at Inchon, the NKPA withdrew from the Pusan area pursued by the U.S. Eighth Army. In an effort to trap and destroy the retreating army, the First Marine Division landed on the east coast at Wonsan on 25 October 1950. It then pushed north toward the Chosin Reservoir as part of a three-pronged attack by UN forces. The military and political objective no longer was the restoration of the 38th parallel, but the UN occupation of the entire peninsula to the Yalu River and the reunification of the Korean people.

Unknown to GEN MacArthur and his UN forces was the early October decision of Mao Tse-tung, Chairman of the Communist Party of China, to assist North Korea militarily. The first contingent of approximately 300,000 Chinese troops of a planned 39 divisions entered North Korea during October with plans for a late November offensive.

By 27 November, the Fifth and Seventh Regiments of the First Marine Division had reached Yudam-ni, a town west of the Chosin Reservoir nearly 50 air miles from the Yalu River. Almost immediately the units were attacked and isolated from the forward command post of the Division 14 miles south at Hagaru. Within days an estimated eight Communist Chinese divisions surrounded the entire Division which was soon on the verge of annihilation.

On 1 December the Fifth and Seventh Regiments began a retreat from Yudam-ni. For nearly 80 hours through mountainous terrain, snow, sub-zero temperatures, and constant attack, they fought their way into Hagaru. They arrived 4 December, bringing with them 1,500 casualties, one-third being frostbite injuries.(*7*)

The Division breakout from Hagaru began 6 December. After fighting in similar conditions through the enemy encirclement, they arrived at Koto-ri

on 7 December. From Koto-ri, the Division attacked south and entered the Hamhung-Hungnam area, 11 December. This ended one of the truly epic offensive withdrawals in military history.

The First Medical Battalion was in close support of the Division throughout the campaign. Immediately after landing it established hospitals at Wonsan and Hungnam. As the Marines quickly moved north, the Wonsan hospital merged with the hospital at Hungnam. An annex was set up at Hamhung. Concurrently, the USS *Consolation* (AH-15) berthed in Hungnam Harbor.

The Battalion was staging a forward hospital at Hagaru and clearing stations at Chinhung-ni and Koto-ri to support the Division movements toward Yuham-ni when the Chinese offensive struck. During 28 November, the Battalion received 939 casualties, the largest number of casualties the Marine Corps experienced in a single day while in Korea. One hundred sixty-one were killed in action or died of wounds. There were 539 wounded in action and 239 other casualties, mostly cold injuries.(*8*)

The Communist Chinese assault interdicted the evacuation route between Yudam-ni and Hagaru. Only the most seriously wounded could be evacuated by air because of the limited number of available helicopters and light aircraft and poor weather conditions. Medical officers and hospital corpsmen had to perform as best they could with limited supplies, in temperatures ranging from 10-20 degrees below zero.

LTJG Henry Litvin remembered his experience in Yudam-ni. When the Marines were short of hospital corpsmen:

"Then I'd have to look over what we had left. No one ever complained. They knew what was coming and they'd look at me with stoic eyes. I'd order one to turn to. He'd mumble something like, 'Yes, Doctor,' or maybe, 'Aye, aye, sir,' grab his gear, and take off on the double. Some of the time they'd be back with a wound of their own and some of the time they'd never come back—not alive, anyway."(*9*)

He also recalled it being so cold that the blood supplies froze and that corpsmen stuck bottles of morphine "in their crotches to keep them from freezing." Blood freezing in a wound would look like a huge piece of "cotton candy."(*10*)

The medical situation was worsening at Hagaru. By 30 November the total number of Marine casualties was estimated to be 2,000.(*11*) Air evacuation was also limited. To improve this, Marine engineers worked day and night with soil frozen solid to expand the airstrip to accommodate C-47s. On 1 December, the first C-47 landed on a half completed runway. During the next 3 days under the direction of CAPT Hering, evacuations occurred at the rate of 1,000 per day.(*12*)

The arrival of the Fifth and Seventh Regiments and their 1,500 casualties at Hagaru on 4 December presented an enormous challenge to the already overburdened medical personnel. The wounded and the frostbitten had to be treated as quickly as possible and the helpless had to be evacuated before the breakout to Koto-ri began. Three-hundred more casualties from a relief column attempting to fight its way to Hagaru from Koto-ri arrived on 6 December, delaying the movement of medical staff out of Hagaru, and resulting in their being part of the last contingent to leave.

Surgical teams flew to Koto-ri to be available to assist the retreating Division. There they worked around the clock to provide care so that the Division could move expeditiously to Chinhung-ni and finally, Hamhung. From 26 November to their arrival in the Hamhung-Hungnam area on 11 December, the Medical Battalion had treated 7,350 casualties.(*13*)

The achievements of the Medical Battalion of the First Marine Division were truly heroic. Medical Battalion men and women completed this enormous task by working almost incessantly "often within 200 yards of the frontline" with complete disregard of the constant nearby rifle and mortar fire.(*14*) CAPT Hering later praised the Battalion's performance. All would have been impossible, he said, "were it not for those fantastically courageous Navy Corpsmen and fine young Battalion and Regimental medical officers. Let us," he continued, "be humble in the knowledge of the sacrifice those men made in their unselfish, co-operative efforts to save the lives of their comrades."(*15*)

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4. Montrose and Canzona, "The Inchon-Seoul Operation", p. 130.

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9. Berry H, "Hank Litvin: The Doctor Goes to War," in *Hey, Mac, Where Ya Been?*, New York: St. Martin's Press, 1988, p. 100.

10. ibid., pp. 104-105.

11. *The History of the Navy Medical Department of the United States Navy, 1945-1955*, p. 140.

12. ibid., p. 141.

13. ibid., p. 143.

14. U.S. Navy Department Document, Code 216, *Military Medical Experience[sic] During the United Nations Police Action in Korea, June 1950 to 1 April 1951*, Korea File, BUMED Archives, Washington, DC, pp. 23-24.

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Dr. Ginchereau is Director of Occupational Health Services, St. Francis Health System, Pittsburgh, PA. He is assigned to Fleet Hospital Fort Dix, NJ, Det. 01.

THE AMERICAN ASSOCIATION OF NAVAL HOSPITAL CORPSMEN WILL BE HAVING ITS ANNUAL CONVENTION IN BRANSON, MISSOURI SEPTEMBER 20-24, 2000. HOSPITAL CORPSMEN FROM PAST AND PRESENT CAN INTERACT, LISTEN TO SPEAKERS, AND TRADE SEA-STORIES. FOR MORE INFORMATION CONTACT: MR JOHN GILLENWATERS 2820 OLD ROBINSON ROAD WACO, TEXAS 76706-3373 OR CALL (254)-662-3956.

Images of Korea

Battle Casualty - members of the 7th Marine Regiment in Korea step carefully as they carrry a wounded comrade to the nearest aid station.

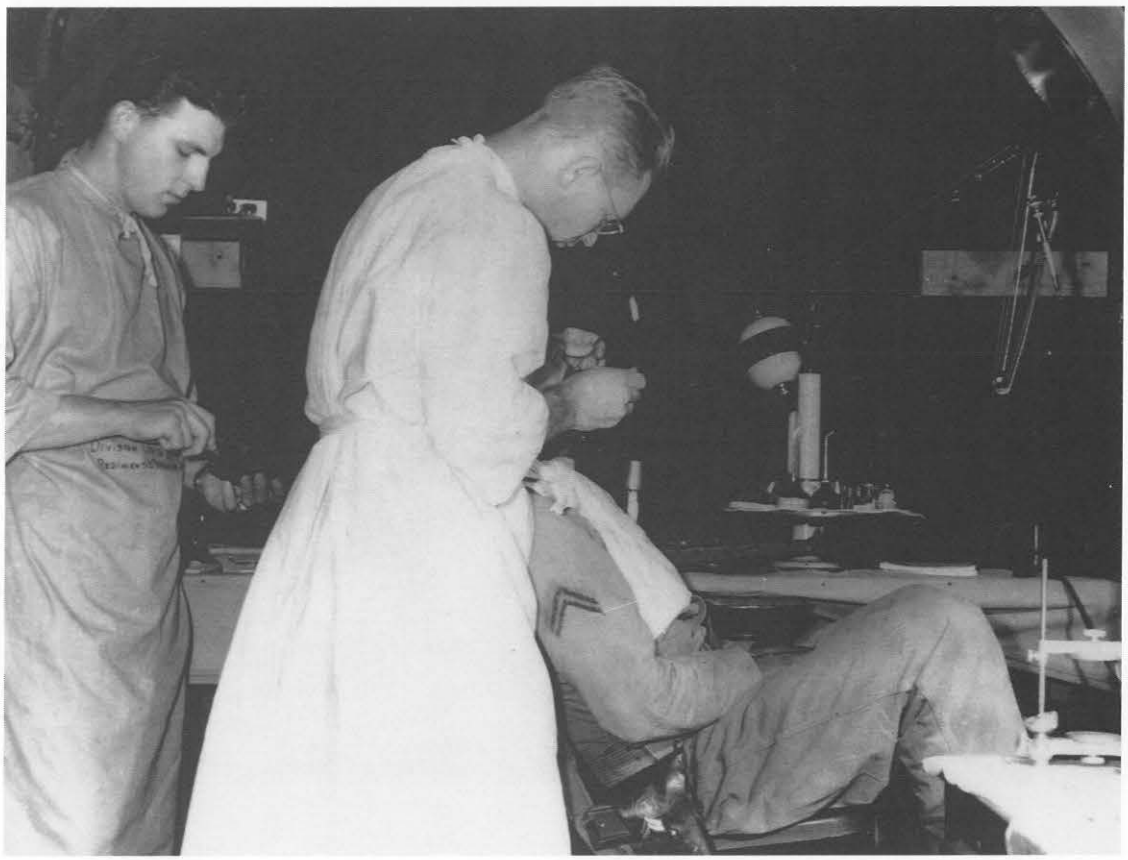
Photos from BUMED Archives

A Marine casualty is loaded aboard a helicopter.

Wounded Marine rides trolley to aid station. The device was rigged by an officer for the 2nd Battalion, 1st Marine Division.

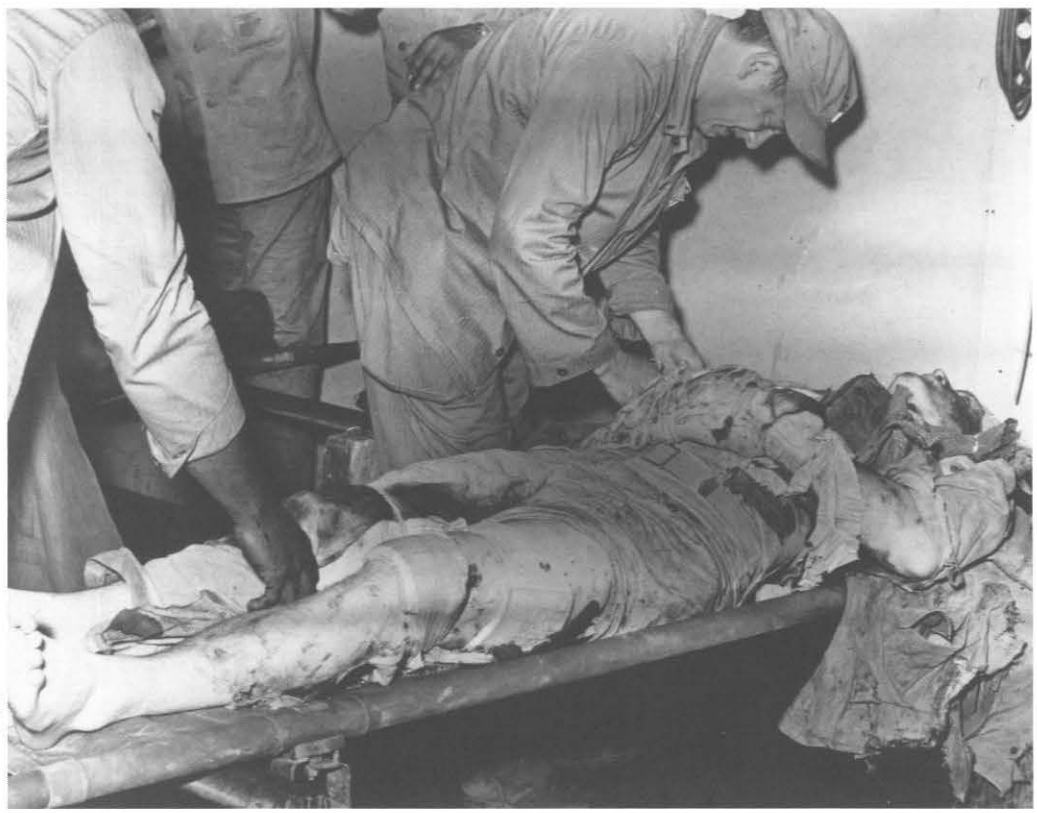
Withdrawal from the Chosin Reservoir.

Liquid life is administered by Navy corpsman at Marine's medical aid station somewhere near the Naktong River front. August 1950.



Still carrying his sidearm, a Marine receives dental care in a clinic near the front.

Field surgery set up in schoolhouse below Seoul. Charlie and Dog Companies reinforced by two surgical teams handled 2,014 casualties in 14 days.



Bunker HIll casualty. 18 September 1952. Physician cuts away wounded Marine's flak jacket.

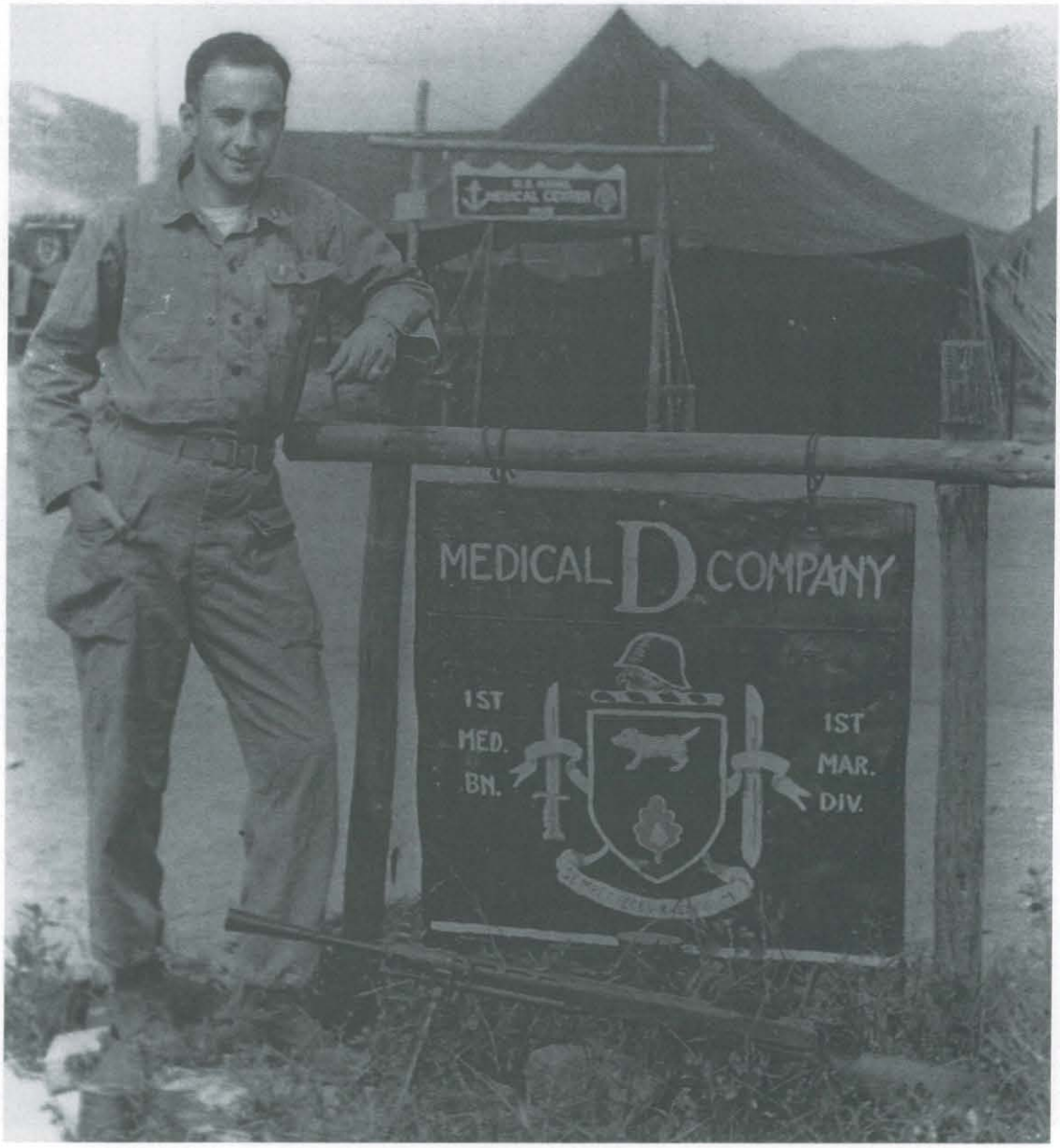
Hospital corpsman gives first aid to a Marine wounded in Naktong area fighting - September 1950.

Operating tables and surgeons inside minor surgery tent.

Absent his left arm and right leg, HN Dan Skiles recovers aboard USS *Haven*.

A Surgeon Remembers Korea

Hermes Grillo, M.D.



LTJG Hermes Grillo, Korea 1951

New Englander Hermes Grillo attended Harvard Medical School under Navy auspices during the last days of World War II. When he completed medical school at 23, he began surgical residency at Massachusetts General Hospital in Boston. Three years later when the Korean War broke out Dr. Grillo had become a civilian again. He now had four choices: the Public Health Service, the Air Force, the Army, or Navy. "For someone interested in surgery the Army made sense, but I liked the Navy and I figured I'd do 2 years. . . I'd spend 1 year at sea, and I like the sea. I pictured myself on a ship in the Mediterranean, of course—naturally the sun, the Med squadron, and then, a year in a naval hospital doing something moderately interesting."

After a very short tour at Naval Hospital Chelsea, MA, where he worked in neurosurgery, Grillo received orders to the Fleet Marine Force. That could mean only one thing, his dream of serving aboard ship in the Med was over.

Following orientation at Camp Lejeune's Field Medical School, LTJG Grillo went with the First Marine Division to Korea. His introduction to the war was immediate and dramatic.

They got us together on the airfield and told us we'd be flying up to the forward area. They said the weather was bad and weren't sure they could land but would try. The weather opened just enough to drop in through clouds onto a gravel strip. We got into an open truck and it was pouring by that point. This would have been the end of February or early April [1951]. It took about 4 hours to finally get to the forward area and by that time it was night.

I reported to the commander, who turned out to be CDR [Richard] Lawrence, head of the medical battalion 1st MARDIV. He was in a dugout with sandbags, a kerosene lantern, and a 4-day growth of beard. Artillery shells were whistling around and we could hear the crackle of machine gun fire. It was really active. The sky was lighting up and I remember thinking, "Geez it's like a World War I movie." It was kind of exciting.

They wanted doctors. In a sense, I think, nobody looked at what we did, or had as backgrounds. So we were just sent up, undifferentiated, as a mass of medical officers.

The commander asked about my background. I said "3 ½ years of surgical residency, sir." He looked at me, his eyes got big and he said, "All surgery?" I told him yes. And he said, "Company D." I didn't know what that meant and so I picked up my pack and my rifle.

You couldn't get there walking so they jeeped me up to an old rice paddy. It was dark and raining and pouring. I got to a tent and that was Co. D. It was a squad tent with a kerosene lantern hanging there. I spoke to the first person I saw sitting on his cot. He told me the commanding officer was over there and he jerked his finger to the rear. I walked to a cot at the back and I could just see a gray rotund belly lying there. I couldn't see a face. I had no idea what I was going to be doing. I thought that I might be helping some red hot board surgeon. That seemed pretty good.

"I was told to report here, sir." There was silence. So I just stood there for awhile. And then a voice with no face attached to it came out of the dark dripping with sarcasm.

"So you're the new surgeon." I quickly figured that I'm the surgeon here, not just an assistant.

I was it, I thought. Well that didn't sound too bad so I just stood there thinking: I don't know what kind of surgical work they do here; maybe it's first aid. I said nothing more; I didn't know what to say. Finally the voice said, "How much training have **you** had?" I said, 3 ½ years, sir." There was dead silence, and then the voice said, "Jesus Christ, another one."

And then I got a stream of vituperation. Not foul language but... "These kids out here are getting wounded bad, they're getting all shot up, their guts are getting shot up. We don't need boys out here; we need men. We need board trained surgeons. We need experienced surgeons. We don't need a bunch of kids like you."

I thought to myself, "It's cold up here. It's wet. It's dangerous. There's machine gun fire out there. It's muddy. This guys sounds like a son-of-a-bitch." I felt like saying, "If you don't want me I'll go home." I knew a little better than to say that so I just stood there.

After awhile he cooled down and that was the end of that. Somebody showed me where my cot was and I stowed my stuff. About 3 minutes

later a corpsman stuck his head in the tent flap and said, "Guy with a belly wound out here."

I walked across to the "hospital" tent and found a kid with a belly wound. I think it was a bunch of fragment wounds. He wasn't in bad shape. He wasn't in shock; he just needed to be fixed. I looked at him quickly. You don't do much of a physical. They are 18 years old, healthy, hard as nails, and they've had a recent wound. That was the whole history for every one of them.

So I went back in. I didn't know the drill. I had no idea what was going on. I didn't even know who anybody was. I went back to the commanding officer and said, "The patient has an abdominal wound, sir, and he needs to be taken care of," or words to that effect. Again there was dead silence. So I wondered, maybe this is like a residency and he's the boss. So I said, "Do you want to check him over, sir?" I just felt we had to get off dead center. The voice said, "Check him over? Hell no! You want anesthesia, I'll give you anesthesia. You don't want it, I'll stay in the sack."

I remember a tremendous feeling of relief. First of all, I had information. I now knew he was the anesthetist. And the second thing was I now felt this guy, whom I thought at this point was a son-of-a-bitch, which he wasn't, was going to be off my back with regard to medical decisions. I felt okay. I don't mind making my own decisions; he won't be around second-guessing me because obviously we are not going to get along. I said, "I want anesthesia." So he clomped out and went in and put the kid to sleep very effectively, very efficiently. I just went to work. There was nothing to it after 3 ½ years of surgical training. I just zipped the kid open and cleaned him up as best I could. The lights were terrible, and the equipment was terrible, but we managed. I sewed up the holes, debrided them, and made sure there were no other things that I overlooked, and then sewed him up. It didn't take very long, and it went very well. He watched very closely, didn't say a word. When I finished he said, "I think we're going to get along." I consider him a friend—he's dead now, poor guy. His name was Dan Pino.

After a few days, he began to warm up, even though he was not a man of many words. He was very laconic, I would say, but a very good guy—very well motivated. I said, "CDR Pino. If I run into some problems I can't handle or don't quite know what to do with, is there somebody I can call? Who can I call?" We had a field telephone. He looked at me thoughtfully for a moment then shook his head and said very sadly, "There's nobody." I couldn't understand that. This is a division, a reinforced division. I don't know whether it was 25,000 men with tanks and artillery and all the rest. And I thought I'm **the** surgeon for this division? This has gotta be crazy.Well, it turned out that I had the most experience of anyone in that division.

The first place we were was someplace south of Inje, a small city up toward the [38th] parallel. We were actually on the side of a gently sliding little hill, which went down into a rice paddy. At that point it was very small. When wounded men came in and if they were in good shape they would put the stretchers on the ground with the head up the hill. If they were in shock they would put them with his head down the hill. We had one operating tent, another debriding tent, a minor operating room, and then a couple of squad tents for the post-ops, who were evacuated very promptly to Company A—the medical company. If they were minor wounds they would go back down there until they got well enough to go back to the front. If they had major wounds we kept them until they were stable. And then we tried to move them out as fast as possible because our conditions were terrible.

That summer they started the so-called Panmunjom truce talks. We actually had our heaviest casualties that fall when we decided to "straighten the line." We had a couple of thousand casualties in a couple of days. It was a slaughterhouse because the Marines went up the hill against bunkers where the North Koreans were dug in. Occasionally, things would quiet down a little bit and then we would have another great run. With our limited personnel it didn't take long to absolutely saturate us.

The medical organization was like this: Theoretically, you had battalion surgeons, battalion aid stations. Then you had collecting and clearing companies—C, D, and E. Then there was the base medical company, Company A, and that was supposed to be on the beach. And from the beach, patients would evacuate to a hospital ship, where they would have surgery. That was the theory.

We were close to the 38th parallel at that point. We eventually ended up near the Punch Bowl, north of the parallel. The hospital then was in Pusan, a long way down. Obviously if you tried to move the wounded down there, many would never get there. As you know, the helicopters were helpful. But for the largest percentage of wounded, the helicopters were theoretical. First of all, you had the mountains. Even on good days, the fog often didn't clear until 10:00 in the morning.

Most of the time ambulances brought down the wounded. In the

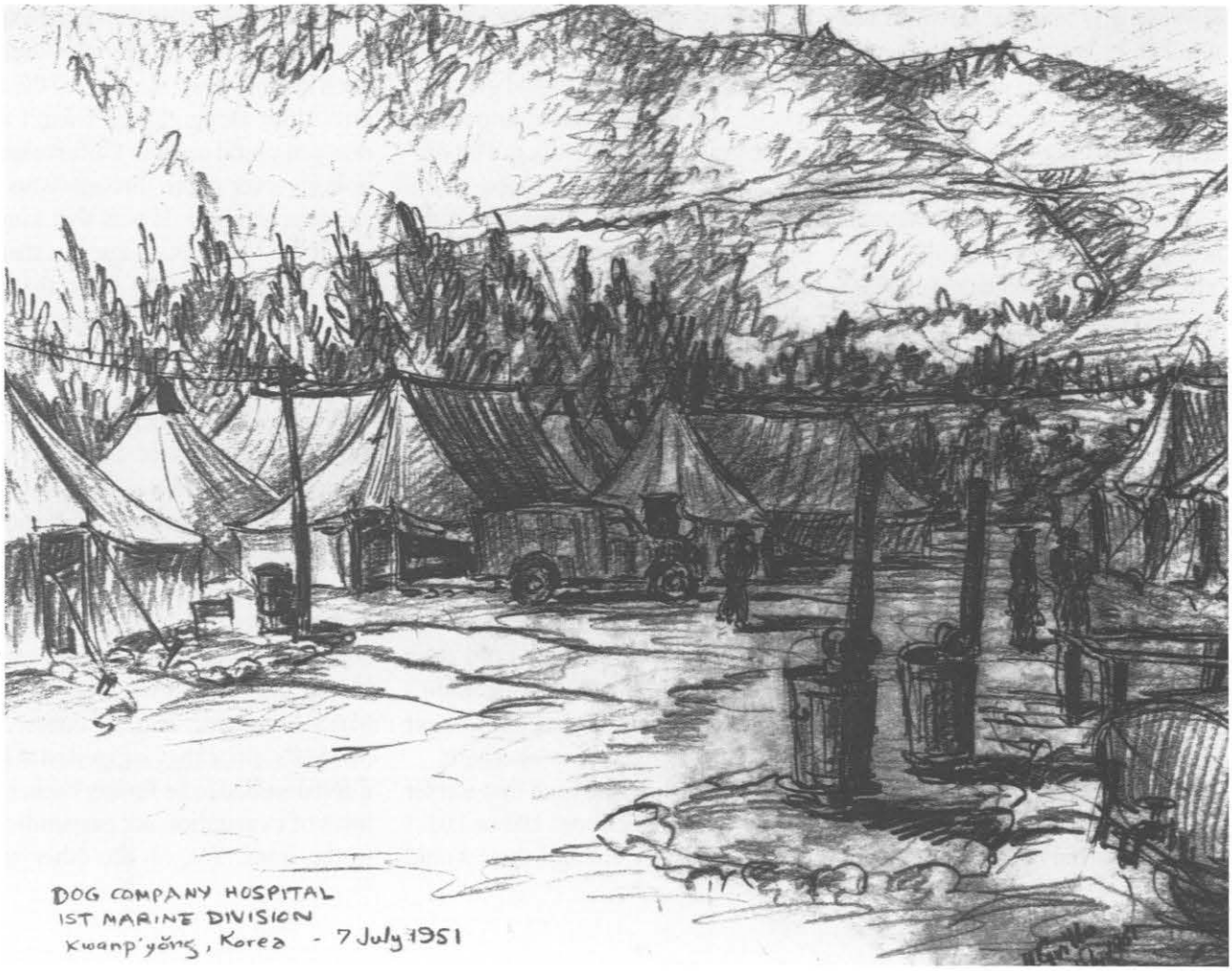


Photo and sketch courtesy of Dr. Hermes Grillo

mountains they used to bulldoze roads out of the side of a mountain or hill. Sometimes the road would wash out in heavy rains or sometimes they would be moving troops or tanks and the ambulances had to wait because they were not first priority.

So they had reorganized medical evacuations. They took a couple of the collecting/clearing companies and made them into hospital units. When I was there, there were two. Ours was Dog Company and then there was Easy Med Company. Those two were made into surgical units of a sort. The advantage was that we were very close because theoretically we supported one regiment. There were two regiments up and one back in reserve. Ours was the Fifth Marines. We also had a second regiment of Korean Marines and we gave medical support to them because they had no other medical support. They were hellions, a bunch of youngsters who were determined to do anything that the U.S. Marines could do and do it better. They got into all kinds of trouble.

We also treated anything that came down the line—U.S. Army troops because often we would have an Army group next to the Marines, the next unit over. Their collecting and clearing was sometimes to the rear of where we were doing surgery. If they had a really badly wounded man they would not send him further back to the rear to a MASH which was many miles back. A MASH supported a division rather than a regiment. They would send the patient up to the front to us to be operated on because we were 15 minutes away and the other MASH might be several hours back.

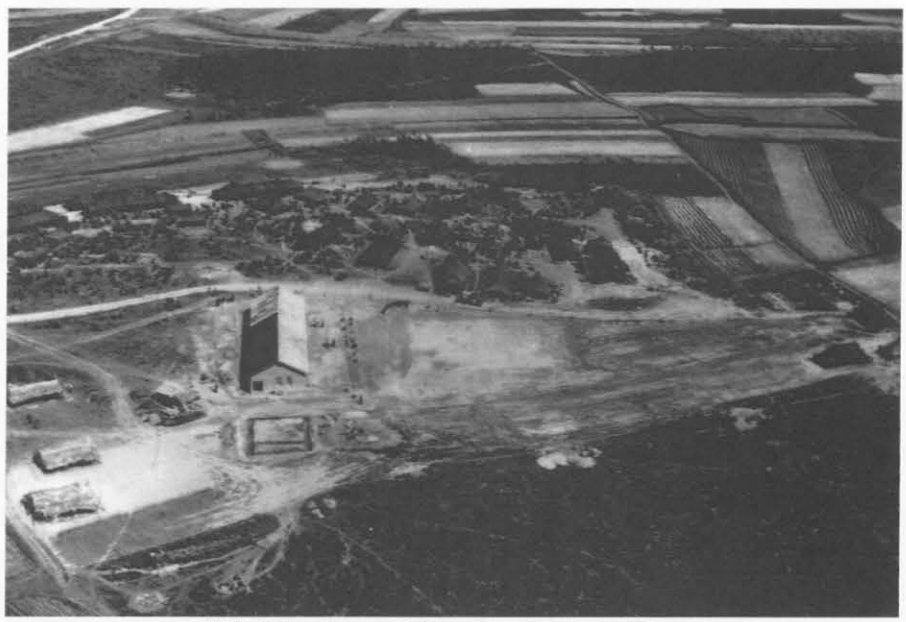
The hospital ships weren't of any immediate use. What they did do, as far as I understand it, was this. After we debrided the relatively minor wounds, we would get them out the next day, or even the same day, in ambulances back to Company A,

where they held them. The worst ones they eventually shipped down to the hospital ship. We would keep the severely wounded men until they were stable, which was usually 5 to 7 days. And then we'd get them the hell out of there and they would go back to the hospital ship. Some of them made it directly to Yokosuka Naval Hospital after they had been triaged. Most of the severely wounded ones eventually ended up in Yokosuka. One of my friends from Mass General, a year behind me in residency, was on the surgical staff there. He saw a lot of my patients after they got there. He could later tell me about cases and what happened to them. That was the general triage. But the definitive surgery was done in our units. There were five doctors but I was the only surgeon.

Basically, we had only one major operating room, and that was mine. I processed the wounded as fast as I could. They did work out a system later on, where they could direct helicopters either to Easy Med or to us, depending upon who was or was not bombed with cases at the time. Occasionally a company would get overwhelmed. I think it was Company A, at one point, that suddenly got hit during an attack. They were overwhelmed and they called us on the field telephone. Pino said okay we'd come down. So he and I got in a jeep and drove down there. They set us up in a tent and we just operated for what seemed to me several days steady. I never did know. Sometimes I would step out and it was day and other times it was night. You'd go out and pee, and then they'd bring you a hamburger or a sandwich and some coffee and I'd go back. I was only 26 or 27 at that time. I actually got to a point where I thought I would drop from exhaustion but we just couldn't stop. In my own unit I couldn't ever stop since there was no alternate.

I got the flu some time that winter and I was running about 102 or 103. I would lie in my cot and they would get a Marine on the table and then would call me. I'd go through the snow and operate on the guy and then go back and lie down again until the next one came along. There wasn't anyone you could call on. Unfortunately, nobody ever came through who had surgical training. It was that kind of situation. One advantage was that we were so close to the front that I'm sure we probably saved people who would never have made it back to the rear.

That was the principal concept that various consultants came up with from their experience in World War II. Do definitive surgery—not patches and dressings and such—as close to the front as possible so that you can immediately treat casualties who are bleeding massively, who have guts blown out and so on. That was the MASH concept. But, of course, the MASH's, since they supported at least a division, had to be further back, since lines of evacuation are perpendicular to the front. We, on the other hand,



"D" Collecting and Clearing Company, Korea

Photos from BUMED Archives

"E" Med. Co. (Easy Med) Korea, Battalion unknown.

could be right up close because, theoretically, we were only dealing with a regiment. That was an advantage and it worked out pretty well, I think.

Equipment-wise, it was so bad that it taught me a tremendous amount about improvisation, which has served me well for the rest of my career. We had a miserable little kerosene sterilizer. We had an operating table, which was a small collapsible metal thing that was so low to the ground we stood it on ammunition cases to get it up to a height where I could use it and not have to break my back. You could not adjust it in any way. You just had to put the patient on it and then move him around.

We had plenty of sterile supplies, linens and such. We had no true operating room lights. We had a bulb hanging from a cord over the table. I stole a reflector from an engineering searchlight and put that over the top of the bulb, which made it a little better. I borrowed an engineer's searchlight once and it was so hot it cooked and desiccated the tissues so I got rid of that in a hurry. We had no real operating room lights. Initially, I learned to operate with a flashlight clipped to the back of my belt. Sometimes at night the lights would go out; the generators were not dependable, and everyone would be stumbling around and I would say, "Reach in my back pocket and you will find a flashlight." And somebody would fumble around. I remember finishing a bowel anastomosis with this flashlight.

We had a very thin supply of instruments in terms of variations and variety. But you know you can do most of that kind of surgery with ordinary instruments. We had no suction machines. So when I had a belly full of feces and exudate and twigs and blood, I would just scoop it out with my hand onto the dirt floor. And then we would take big abdominal pads and just wipe the belly out, pour saline in and clean it out as best we could. If there was a mess of bleeding welling up, all you could do was to put pressure on things and then slowly work your way in, because there was no suction of any sort available. For deep wounds, you were way down somewhere in the depths.

There were no deep abdominal retractors. There were all these miserable little things a few centimeters long. I took some 155 mm brass shell cases—which are big and heavy and long—and I drew on them outlines of retractors that I wanted, like Deaver retractors. On a piece of paper I drew the curve I wanted and we took them down to the engineers and they cut these for me from the heavy brass, bent and filed them, and these are what we used. They weighed a ton. I wish I had taken one back for a souvenir but I had to leave them there for other guys to use. But because we

Front line hospital, campsite of "C" Med Co, 1st Med Battalion, June 1952

had no big abdominal retractors, we had to use these things and they were very helpful.

They shipped us blood, which was all universal donor or blood with substances to neutralize the antibodies. There was no cross matching. The blood was just poured in. And we used huge amounts of it, sometimes 6 or 8 [units] for a guy who was exsanguinating when he arrived. The problem was that there was a custom. As new blood came in, each unit to the rear would take the new blood, put it in their refrigerator, and send the old stuff forward. So the stuff we got—where a lot of blood was really used—was full of stringy clots and it looked awful. I don't know how many people we killed with that blood, probably not too many; they seemed to survive it. We had a refrigerator and kept it cool with a generator. We had all the blood we needed. There was never a shortage.

This was not MASH. MASH was very well equipped in comparison. MASH was not bad. MASH had good equipment, good lighting, x-ray machines, and a corps of trained surgeons who were at my level. And these were the second order people. They had board trained Army surgeons. They had nurses. They had endless supplies and they had staffs that didn't have to work around the clock because they had enough people; they could be on rotations. Of course, when they got bombed everyone would all pitch in, but normally, you'd be on duty, you'd be off duty. We had no on-duty/off-duty for the doctors.

We were on duty and when it got very busy, we just went and went and went. There was never even a question in my mind of ever stopping. I didn't feel I had the option. There's a guy on the table and you have to do something for him. We had enough corpsmen so they worked in shifts. But I remember one time when we were absolutely overwhelmed, just working away. I looked up and saw this corpsman—a good guy—who worked in the operating room. I said, "You know you've been on for 24 hours now." He looked at me and said, "Well, we figured if the doctors can do it, we can do it." These were the good things you saw; these fellows felt that they were obligated too. And the morale went zooming up after we got things moving and better organized.

We moved about four or five times while [I was in Korea] and I can't even tell you where. It was always some valley. The commanding officer would go up in a jeep with the Medical Service Corps officer and they'd find a place in the area close enough to the front but a reasonably safe place, sometimes behind a hill or in a little flat place but near the MSR (main supply route) so they could get to us

quickly. We first started in a rice paddy and then we moved to Inje, then up to a valley that was just over a ridge from the Fifth Marines. They brought the wounded back over the hill.

Then we moved again another time. The final place got pretty well set up once the talks started in Panmunjom. Later, we got wooden decks for the operating tents, which we hadn't had. By this time, we had figured out a way to bring jeeps up so we could hook up to their generators if we lost power at night. We even had screens for the hot weather late that fall. Before that I always had one extra corpsman stand at the table keeping the flies off. It was aesthetically troublesome to me to be sewing up someone's intestine and have a fly sit on it. This didn't seem to do anyone any harm; the patients did all right but it was very upsetting to me.

When I think about it, the only obligation the Navy Medical Department had in the Korean War was the Marine division. Oh, the Navy ships went up and down the coast and fired a few shells and occasionally an artillery observer went ashore. They had 25,000 men there getting shot at, and out of the whole huge complex of the Navy Medical Department, they couldn't muster up two board surgeons—that would have been the minimum need, or even a couple of more guys like myself and there were lots of them. When I got back to St. Albans Naval Hospital, the place was just loaded with surgeons of all types—regular Navy, reservists, and so on. You would also think they could get somebody who had at least 1 year of anesthesia residency.

I left Korea just before Christmas near the close of '51. When I got the information that I could leave the next day—my number had come up—I had this tremendous sense of relief. But I was so involved in this thing and thought we were doing a good job. You have this feeling. You've got a job to do here and you're doing it well and who's going to take over? Then I thought, "You've gotta be crazy. Leave when you can." ❑

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Medical Aid station for Marines behind the Naktong River.

Quiet Heroes: Navy Nurses of the Korean War

CDR Frances Omori, USN

The following article contains excerpts from the newly published book
Quiet Heroes: Navy Nurses of the Korean War 1950-1953, Far East Command.

Photo courtesy of Marilyn Ewing Affleck

Medical staff of Ward "V" (left to right) Dr. Francis, LTJG Marilyn Ewing, Dr. William Strong, LT Dorothy Lukowski, LT Ruth Scanlon, HN William Price, LTJG Jean Ellis, and Hospital Corpsman Besemar (kneeling).

Few Americans realize that about 3,000 Navy nurses served during the Korean War with uncommon valor at home and overseas. Indeed, they were the quiet heroes of that conflict. They did their jobs and much more. They took continual care of routine tasks, yet responded immediately to life-threatening emergencies.

The wounded arrived from the muddy, frozen Korean battlefields bloody, filthy, and in excruciating pain. Quickly getting patients settled and comfortable was foremost on their minds. They looked into the frightened eyes of their patients and saw unshaven faces streaked with mud, mucus, dried blood mixed with grit and grime. They saw uniforms encrusted with blood and infested with lice. They smelled uniforms stained with stagnant water, urine, and diarrhea. They saw bodies encased in mud so dried and hard that they had to chisel and scrub it off. They saw feet so frostbitten that the skin was black and rotting away, exposing bone. They saw wounds treated and bandaged in the field, now oozing with pus and crawling with maggots. They saw mangled bones and skulls cracked open by shrapnel. They saw flesh hanging off the bones of soldiers who had stepped on land mines. They saw patients lined up stretcher after stretcher after stretcher. They heard the moaning, screaming, crying, cussing, and shrieking of the wounded packed into crowded hospital passageways or deposited in warehouses until their disposition could be determined. Those suffering from combat fatigue were stashed under stairwells because there was just no room anywhere else.

Hospital corpsmen cleaned, scrubbed, and bathed patients at a furious pace, but there was always another trainload, another bus load, another ambulance, another chopper. There were always more patients and no room.

For 50 years few have heard of these nurses who worked so gallantly near the war zone. The nurses felt they did nothing special; they were just doing their jobs. Yet, in the hearts and souls of their Marine patients, they were heroes. For a half century, the Marines of the First Division have wanted to thank their nurses, but could not locate them after the war because, in most cases, they didn't know their names. What they did remember were nurses with pretty blue or brown eyes. They carried in their memories the nurses' soft touch, kind smile, gentle voice, caring attention, healing laughter, a strong presence and, for most, maybe a nickname.

Naval Hospital Yokosuka

U.S. Naval Hospital Yokosuka was established in August 1950 less than 2 months after the Korean War began. Through efforts of Chief Nurse Alberta Burk the hospital had to expand immediately. Within months, it accommodated about 5,000 patients.

During the 48-hour period of 6 and 7 December, a total of 2,022 patients were admitted. About this time, GYSGT William H. Yarnall, "I" Company, 3rd Battalion, 1st Marines, arrived at Naval Hospital Yokosuka. He was evacuated sometime between 27 November 1950 and 1 December 1950. His first stop was an Army hospital in Japan.

At Yokosuka Naval Hospital, I was put in a hallway. I was told that there were no beds at the moment. Between the nurses and the corpsmen, it didn't matter about the hallway. They made it seem like the Ritz Hotel. If we made one moan a nurse and a corpsman were immediately at our side.

The overall treatment I received from the hands of our Navy Nurses was the best. There are no words to make my feelings known to you, save to say, God bless the naval nursing corps. You all deserve the Medal of Honor.

Photos from BUMED Archives

Front Gate, U. S. Naval Hospital, Yokosuka, Japan 1951

Safe aboard USS *Repose* (AH-16), patient SGT Paul E. Robinson, USMC, tells Navy Nurse Laura J. Emery how he stopped a sniper's bullet in the frigid mountains above Andong, Korea.

Hospital Ships

Whether they were anchored in Pusan, Inchon, Hungnam, or anywhere in Korean waters, the big white ships with the bright red crosses became known as sanctuaries. The wounded, the critically injured, the sick, and the battle fatigued knew they could find solace aboard *Consolation*, *Repose*, and *Haven*.

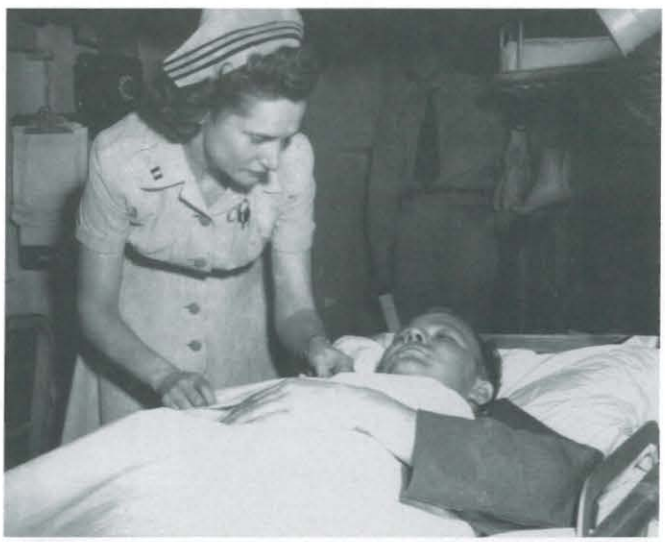
In April 1951, the Navy's *All Hands* Magazine reported that more than 25,000 patients had been treated on board *Consolation* during approximately 7 months in the Korean theater establishing a record for hospital ships.

In October 1951, SGT John L. Fenwick, USMCR became a *Consolation* patient.

> ***I was wounded for the third time 10 days before I was rotated home. I was hit by a North Korean machine gun on 5 October 1951.***
>
> ***Three bullets hit my ammo belt. These were the worst gun shot wounds. They struck me in my left flank involving the iliac crest, three vertebras [sic], destroyed the sacro-iliac joint, severed an artery. I had an exit wound in my lower back the size of a fist.***

Medevaced to the field hospital, "Easy Med," LCDR Phil Cerack operated on Fenwick. He removed 18 inches of small intestine, using a total of 837 sutures during surgery.

> ***After all the surgical tubes were removed, I was flown to the* Consolation. *When I arrived there, I thought I was in heaven. Large bunks with clean sheets and Navy nurses. My nurse was a Lieutenant Commander, a World War II veteran. She was wonderful.***
>
> ***She asked me if I would like some ice cream. I couldn't believe it when she asked me what flavor I wanted. I grabbed her hand and kissed it. I said, "You nurses really are angels of mercy." Then I lost it. I cried like a baby slobbering all over her hand. It was hard to believe after a year of suffering deprivations. We were near starvation. There was so much pain and suffering. And now there was something as great as this. This nurse took care of me. It was hard to believe it was true.***



LT Eveline Kittelson, NC, adjusts a sheet around a wounded Marine aboard USS *Repose* - March 1951.

Repose

In a letter dated 15 October 1950, CDR Emery described her first 3 weeks in Pusan:

> ***The first week we were here we got about two hours of sleep every 24 hours. Now we work from 8 am to 10 pm. We are on call for trains or planes that arrive during the night. All we do is work and take a few moments for chow.***
>
> ***We would give most anything for more nurses. Our capacity is 30 and we have 15 for the entire ship.***

LT Eveline Kittilson also recalls the frantic pace:

> ***The patients were sent to us by train. It could take 12-14 hours. The trains started arriving about 1800. They continued until almost midnight every day. Most of the seriously injured were sent to us. We received anywhere from 100-150 patients each night. Their ages ranged from 17-20 years old.***

MGYSGT Kurt Loewy, USMC (Ret.) sums it up:

> ***The nurses aboard the* Repose *were like a letter from home, a breath of fresh air, a slice of Mom's apple pie and a cold beer, all rolled into one!***

On board USS *Repose*, Thanksgiving Day 1952.

Haven

When the Korean War broke out, *Benevolence* was bound for Korea. On 25 August 1950, during sea trials, she collided with a civilian vessel and sank 1.89 miles due west of Seal Rock off San Francisco. *Haven* was taken out of mothballs and recalled to active duty to replace the lost hospital ship. *Haven* was recommissioned on 15 September 1950.

Marine 1stSGT Andrew Peter Boquet, stricken with infectious hepatitis and jaundice, boarded the *Haven* in March 1951:

> ***My first contact with a Navy nurse was on the hospital ship* Haven. *I was filthy dirty and sick as a dog. This nurse had me bathe and dump my clothing. She gave me clean PJs and put me in a nice clean bunk. She then gave me a tall cold glass of milk. She looked so beautiful in her spotless white uniform. I'll never forget her. Don't know her name.***

It has been 50 years since 3,000 Navy nurses made an unselfish commitment to our nation to serve during the Korean War. These quiet heroes, undaunted by adversity, cared for their patients using the breadth of their skills and the depths of their hearts and souls.

After the Korean War, some continued their Navy careers. Others chose to become nursing professionals in the civilian community. Many married and raised families.

Fifty years later the Navy nurses of the Korean War, now in their 70s, 80s, and 90s, still exude the undaunted faith that "it will all work out." They still have the resilience to bounce back from adversity, allowing themselves to re-juggle their plans and go down a different route. Their contagious, effervescent spirit still fills rooms wherever they are. ❑

CDR Omori is the Arms Control Policy Manager, Defense Threat Reduction Agency, Dulles, VA. *Quiet Heroes* is published by Smith House Press and may be purchased by calling 1-888 220-5402. Address: 2700 Rice St. St. Paul, MN 55113.

Book Review

***MASH: An Army Surgeon in Korea* by Dr. Otto F. Apel, Jr. The University Press of Kentucky, Lexington, KY. 222 pages, 1998.**

Dr. Otto Apel had just completed his residency and was paying back his education offered through the Navy's Specialized Training Program, known as The V-12 Program. Like many going through school after World War II, Dr. Apel looked forward to a downsizing military and the possibility of starting a medical career in the civilian world without going through any rigorous military payback.

Dr. Apel then got a letter that would change his life. Rather than beginning his career in the Navy, he would practice medicine assigned to the Army alongside other physicians, nurses, medics, and other ratings that manned the 8076th Mobile Army Surgical Hospital (MASH).

Apel's account exposes the true nature of the Korean conflict from a medical perspective. Arriving in the summer of 1951, Dr. Apel immediately scrubbed down and proceeded to be on his feet for 3 days. As his ankles swelled to twice their normal size, he was forced to cut open his combat boots. When the young physician asked the senior surgeon when their shift would end, the man who was himself in the middle of a case, replied that there were three surgeons here, and that every one of them was in the same tent. "If you need a rest, sit down by the 5-gallon can, and remember while you are napping there are men dying on these litters waiting for you to get up." The author is very critical of the U.S. Army and how ill prepared many were for the types of combat injuries they encountered.

The book is an excellent account of the history of MASH units and how they operated in Korea. One MASH was known for neurosurgery while Dr. Apel's unit was known for arterial repair.

An entire chapter discusses the role and evolution of helicopters and their use to evacuate patients from the battle zone. The old H-13 would carry two litters open on its skids. In one incident, a Korean patient woke up and tried to get inside the pilot's bubble enclosed cockpit. The pilot dropped suddenly, convincing the patient to remain on the litter for the ride.

Apel and many who were with him did not use the term MEDEVAC like we do today, but simply called them copters or choppers; some referred to them as mechanized angels.

Dr. Apel is one of the characters the movie and 1970s TV series M*A*S*H was based upon, but he is quick to set the record straight, pointing out that he and his colleagues had no time for football games, and that M*A*S*H was tailored to a Vietnam era audience. However, the shower incident actually occurred, with a helicopter accidentally blowing a tarp off the nurse's shower tent.

Apel and his group treated cases from Heartbreak Ridge, Pork Chop Hill, and he highlights the types of injuries he encountered. Since Korea involved United Nations forces, he notes that a lot of abdominal wounds could be attributed to Turkish and Ethiopian troops who liked hand-to-hand combat with knives. One chapter deals with living conditions of the MASH unit and what the doctors, nurses, and support personnel did to break the daily grind of numerous stretchers and surgical cases.

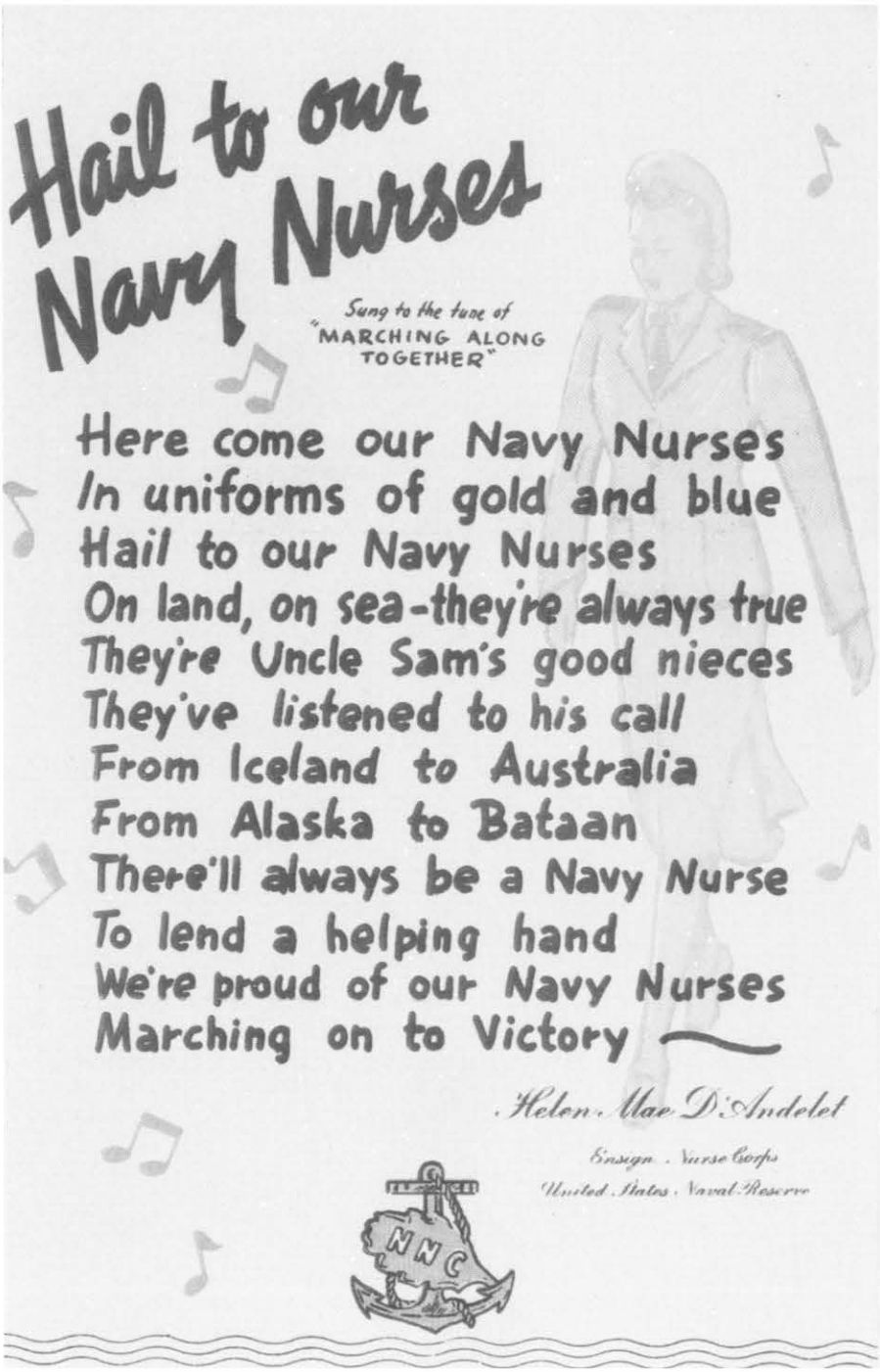
Besides helicopters, the Korean War brought many innovations including perfecting the use of plasma and O-positive blood to stabilize patients suffering from blood-loss shock. The author also describes advances in arterial repair which reduced the number of amputations. Several pages detail the exact procedure used during the Korean War. There is an account of how senior Army surgeons refused to allow arterial repair and how it was fought over because of the newness of the procedure.

Apel's MASH moved seven times in 6 months but despite this disruption, the 8076th would treat 608 patients and perform 244 surgeries in one 24-hour period.

As General MacArthur conducted the landing at Inchon and drove North Korean forces all the way to the Yalu River, the MASH's really earned the mobile portion of their name. When the Chinese crossed the Yalu and in turn assaulted United Nations forces, driving them back across the 38th parallel, the 8076th, 8063rd, and 8055th MASH went too. *MASH: An Army Surgeon in Korea* is an excellent read and cuts to the core. People make or break a deployment in times of crisis.

—LT Youssef H. Aboul-Enein, MSC, USN, is Plans, Operations and Medical Intelligence Officer, Naval Hospital Great Lakes, IL.

Navy Medicine 1943



World War II Navy Nurse Corps Jingle contributed by LT Youssef H. Aboul-Enein, MSC, USN. Plans, Operations and Medical Intelligence Officer Naval Hospital Great Lakes, IL.

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